MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2007

UNITED HEALTHCARE INSURANCE COMPANY
450 Columbus Blvd.
Hartford, CT 06103

NAIC Company Code 79413
NAIC Group Code 707

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

CERTIFICATE OF COPY

I, **Marcy Morrison**, Commissioner of Insurance of the State of Colorado, do hereby certify that the attached is a true and correct copy of the Market Conduct Examination Report as of December 31, 2007 for **United HealthCare Insurance Company** now on file as a record of this office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal of office at the City and County of Denver on this 28th day of August 2009.

Marcy Morrison
Commissioner of Insurance

UNITED HEALTHCARE INSURANCE COMPANY
450 Columbus Boulevard
Hartford, CT 06103

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2007

Examination Performed by:

Regulatory Consultants, Inc.

Nestor J. Romero, CPA, CFE, CIE
Examiner-In-Charge

Jimmy Potts, FLMI, CLU, AIRC, CIE

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP, ACS, MCM

Lynn L. Zukus, AIE, FLMI

April 30, 2009

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of United HealthCare Insurance Company (the Company) was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which authorize the Insurance Commissioner to examine insurance companies. We examined the Company's records at its office located at 6465 S. Greenwood Plaza Blvd., Suite 300, Englewood, Colorado, 80111. The market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The following market conduct examiners respectfully submit the results of the examination.

Nestor J. Romero, CPA, CFE, CIE

Jimmy Potts, FLMI, CLU, AIRC, CIE

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP, ACS, MCM

Lynn L. Zukus, AIE, FLMI

TABLE OF CONTENTS

SECTION **PAGE**

COMPANY PROFILE

The following profile is based on information provided by the Company:

United HealthCare Insurance Company (formerly The MetraHealth Insurance Company and The Travelers Insurance Company of Illinois), a Connecticut corporation which has its home and principal executive offices at 450 Columbus Boulevard, Hartford, Connecticut 06103 is the Registrant. Registrant is licensed as a life, accident and health insurer in the Virgin Islands, District of Columbia, Commonwealth of the Northern Mariana Islands, American Samoa, Puerto Rico, Guam and in 49 states except New York.

In November 1994, the Registrant re-domesticated from the State of Illinois to the State of Connecticut and changed its name to The MetraHealth Insurance Company. On January 3, 1995, the Registrant became a direct wholly-owned subsidiary of The MetraHealth Companies, Inc., a Delaware general business corporation, by contribution of its outstanding stock from The Travelers Group Inc. On October 2, 1995, UnitedHealth Group incorporated (formerly United HealthCare Corporation) ("United"), a Minnesota general business corporation acquired The MetraHealth Companies, Inc., and its subsidiaries.

On May 31, 1996, The MetraHealth Companies, Inc., the sole shareholder of the Registrant, merged with and into the Registrant with the Registrant as the surviving corporation. As a result of the merger, The MetraHealth Companies, Inc., ceased to exist as a separate entity and United now owned all the outstanding shares of the Registrant directly.

Effective as of January 1, 1997, United Health and Life Insurance Company, a Minnesota domiciled insurance company and affiliate of the Registrant, merged with and into the Registrant with the Registrant as the surviving corporation. As a result of the merger, United Health and Life Insurance Company's two subsidiaries, (1) United HealthCare Insurance Company of Illinois and (2) United HealthCare Insurance Company of Ohio became direct wholly-owned subsidiaries of the Registrant and United Health and Life Insurance Company ceased to exist as a separate legal entity. Also, on January 1, 1997, the Registrant changed its name to United HealthCare Insurance Company from The MetraHealth Insurance Company.

Effective as of June 30, 2000, United HealthCare Insurance Company became a direct wholly-owned subsidiary of UHIC Holdings, Inc. (f/k/a Unimerica, Inc.), a Delaware general business corporation, pursuant to approval of the Connecticut Department of Insurance. UHIC Holdings, Inc., is a direct wholly-owned subsidiary of United HealthCare Services, Inc. ("UHS"), a Minnesota general business corporation. UHS is a direct wholly owned subsidiary of United.

As of December 31, 2004, UHIC Holdings, Inc., owns all of the outstanding shares of the Registrant and United is the ultimate parent in the insurance holding company system.

United HealthCare Insurance Company is licensed to write life and group accident and health business in forty-eight states and American Samoa, the District of Columbia, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands, U.S.

Premium and Market Share as of December 31, 2007:

Total Written Premium:	$775,393,000*
Small Group Written Premium:	$311,989,366 *

Market Share	(as a percentage of Colorado Total Accident and Health):	8.84%
	(as a percentage of Colorado Total Small Group Health Benefit Plans):	24.48%

* As provided in the 2007 edition of the Colorado Insurance Industry Statistical Report
** As provided by the company to the Division in the Small Group Activity Report

PURPOSE AND SCOPE

Independent contract examiners for the Colorado Division of Insurance (Division), in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8), and 10-3-1106, C.R.S., which empower the Commissioner to examine any entity engaged in the insurance business, reviewed certain business practices of United HealthCare Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related to health insurance companies. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

Examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or supplied by the Company. The limited market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The examination included review of the following:

Company Operations and Management
Complaints
Contract Forms
Rates
Applications/Cancellations/Declinations/Rescissions
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to small and large group health insurance laws as they pertained to insurance companies. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance company product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims, or ten percent (10%) for other samples was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception

percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate higher than the minimum tolerance level, the results of any other samples with exception percentages less than the minimum tolerance were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the statutes and regulations as shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-8-521, C.R.S.	Notice to residents.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions
Section 10-16-104.7, C.R.S.	Substance abuse – court-ordered treatment coverage
Section 10-16-105, C.R.S.	Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans – rules.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.7, C.R.S.	Reporting the denial of benefits to the division – rule
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-704, C.R.S.	Network adequacy.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning The Elements Of Certification For Accident and Health Forms
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review And Denial Of Benefits
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issue to Self-employed Business Groups of One
Insurance Regulation 4-2-20	Concerning the Colorado Health Benefit Plan Description Form
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers

Insurance Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Health Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Conversion Coverage

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous limited market conduct examination dated October 9, 2003, which covered the period January 1, 2002 through December 31, 2002.

Consumer Complaints

From a population of 1,405 consumer complaints received directly from insureds and/or providers, a sample of 112 files was selected for review.

Contract Forms

The examiners reviewed the following forms:

MOST COMMONLY SOLD GROUP PPO PLAN -
Form Name: United HealthCare Options PPO Certificate of Coverage
Form Number: PPO Cert I.01.CO (12-2003)

MOST COMMONLY SOLD GROUP INDEMNITY PLAN
Form Name: Managed Indemnity Certificate of Coverage
Form Number: MICERT.I.01.CO (12-2003)

RIDERS, ENDORSEMENTS AND AMENDMENTS USED WITH MOST COMMONLY SOLD GROUP PPO & INDEMNITY PLANS
Form Name: Amendment to Your Certificate of Coverage
Form Number: RPAMD.CMS.I-P.01.CO

APPLICATION USED WITH MOST COMMONLY SOLD GROUP PPO & INDEMNITY PLANS
Form Name: Product and Benefit Selection Form For Small Business
Form Number: None *Date in lower right hand corner of form: 6/03*
Form Name: Employer Application for Small Business
Form Number: SB.ER.07.CO 01/08 380-5241 2/08
Form Name: IMPORTANT INFORMATION FOR SMALL GROUP EMPLOYERS
Form Number: 380-3364 4/04
Form Name: Scheduled Direct Debit Authorization Form
Form Number: 100-8519 3/08

APPLICATION USED WITH LARGE GROUP PLANS
Form Name: Key Account Insured Employer Application
Form Number: 380-1475 02/03

APPLICATIONS USED WITH CONVERSION PLANS
Form Name: Conversion Renewal Application
Form Number: RCONVA.I.01.CO
Form Name: Application For Conversion Of Group Coverage
Form Number: GCAP.I.01.CO
Form Name: Application For Conversion of Group Coverage
Form Number: GCAPP.I.01.CO 12.2005

CONVERSION POLICIES
Form Name: Managed Indemnity Standard Health Benefit Conversion Policy
Form Number: StdMIConv.I.01.CO
Form Name: Options PPO Standard Health Benefit Conversion Policy
Form Number: StdPPOConv.I.01.CO

BASIC AND STANDARD MANDATED HEALTH BENEFIT PLANS
Form Name: United Healthcare Managed Indemnity Basic Limited Mandate Health Benefit Plan for Colorado
Form Number: BASMI.01.CO (1-2006)
Form Name: United Healthcare Options PPO Basic Health Benefit Plan for Colorado
Form Number: BASO.01.CO (1-2004) ***NOTE: CF #15 issued for not updating benefits and Company responded that incorrect version had been initially provided and then provided the 2006 version which required another review. (See Form name & number immediately below)***
Form Name: UnitedHealthcare Options PPO Basic Limited Mandate Health Benefit Plan for Colorado
Form Number: BasPPOCOC.I.01.CO
Riders, Endorsements, And Amendments
Form Name: Amendment to Your Certificate of Coverage
Form Number: DChildAmd-Age25-Gen.I.01.CO
Form Name: Document Information Cover Sheet
Form Number: PolicyBSCSTD.I.01.CO (12-2003)
Form Name: United Healthcare Managed Indemnity Standard Health Benefit Plan for Colorado
Form Number: STDMI.01.CO (1-2006)
Form Name: United Healthcare Options PPO Standard Health Benefit Plan for Colorado
Form Number: STDPPO.01.CO (1-2004) ***NOTE: CF #15 issued for not updating benefits and Company responded that incorrect version had been initially provided and then provided the 2006 version which required another review. (See Form name & number immediately below)***
Form Name: UnitedHealthcare Options PPO Standard Health Benefit Plan for Colorado
Form Number: StdPPOCOC.I.01.CO
Form Name: Uniform Employee Application
Form Number: CO SG 01 (Revised 07/25/06

HEALTH PLAN DESCRIPTION FORMS
Form Name: Colorado Health Plan Description Form-Standard Preferred Provider Plan CO-T
Form Number: CORJMCOT02
Form Name: Colorado Health Plan Description Form-Basic Indemnity Plan CO-U
Form Number: CORKMCOU02
Form Name: Colorado Health Plan Description Form Standard Indemnity Plan CO-
Form Number: CORKMCOC02
Form Name: United HealthCare Choice Plus Plan USA
Form Number**:** COSGMUSA02

CERTIFICATES OF CREDITABLE COVERAGE
Form Name: Certification of Prior Creditable Coverage
Form Number: 5342FEDL Rev 07/21/08
071203
Form Name: UHC Choice Plus Plan Certification Of Coverage
Form Number: 5348FEDR
Rev 02/06/07 071203
Statement of HIPAA Portability Rights
No Form Number

Rates

Rates were reviewed for compliance with the rate filings submitted to the Division as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

Applications

A sample of 113 New Business Application files were randomly selected for review by the examiners from a population of 1,321.

Cancellations/Non-Renewals/Declinations

For the period January 1, 2007 through December 31, 2007 the data provided by the Company indicated a population of 1,821 terminated files. Per the underwriting section of the Company, small business does not decline, rescind or non-renew any cases. The examiners reviewed a randomly selected sample of 113 small group cancelled files for compliance with statutory requirements and contractual obligations:

Claims

In order to determine the Company's compliance with Colorado's prompt payment of claims law as well as the proper and accurate payment of claims, the examiners reviewed the following random samples:

- One hundred nine (109) paid claim files for accuracy of processing
- One hundred eight (108) denied claim files for accuracy of processing
- One hundred nine (109) electronically received paid claim files processed > 30 days and < 90 days
- Forty-three (43) paper received paid claim files processed > 45 days and < 90 days
- Eight-three (83) paid claim files processed > 90 days
- Seventy-six (76) denied claim files reviewed to determine accuracy of quarterly reporting required by the Colorado Division of Insurance
- One hundred eight (108) claims where data indicated that services were provided on the same date of service on both an in-network and out-of-network basis to determine if out-of-network claims were being processed in accordance with law when services were performed in an in-network facility.

Utilization Review

The examiners reviewed the Company's utilization management program including policies and procedures.

The Company has contracted with ACN Group, Inc., for utilization review of physical health services. Physical health services include chiropractic as well as physical and occupational therapy services provided in outpatient, non-hospital based settings.

UnitedHealthcare Services, Inc. is a business unit within UnitedHealth Group that performs the utilization review functions for the Colorado members. Those medical/dental (accidental) services on the required notification list receive pre-service review by staff within this business area.

United Behavioral Health (UBH) is a business unit within UnitedHealth Group that performs the utilization review functions for claims related to mental health or behavioral issues.

The Central Escalation Unit (CEU) manages commercial clinical and administrative appeals and works with its clinical review partners – Medical Claim Review (MCR), Care Coordination (CCR) and Medco Health Solutions, Inc., United Healthcare's pharmacy benefits services administrator – to facilitate all required clinical reviews.

The examiners selected the following random samples for review of the Company's overall utilization review handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons in order to determine compliance with Colorado insurance law:

- One hundred fifteen (115) approved prospective review files
- Eighty-four (84) denied prospective review files
- One hundred thirteen (113) approved retrospective review files
- Eighty-four (84) denied retrospective review files

EXAMINATION REPORT SUMMARY

The examination resulted in a total of thirty-three (33) findings in which the Company did not appear to be in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

Company Operations and Management: The examiners identified four (4) areas of concern in their review of the Company's Operations and Management:

Issue A1: Certifying and using forms that do not comply with Colorado insurance law.

Issue A2: Failure to provide correct form numbers for some forms reported on the Annual Report of Policy Forms as being in use during 2007.

Issue A3: Failure, in some instances, to maintain records required for market conduct purposes.

Issue A4: Failure to report to the Division the correct number of second level and independent external appeals requested and completed in 2007.

Complaints: The examiners identified one (1) area of concern in their review of consumer complaints received directly from insureds or providers.

Issue C1: Failure to enter all written first level and second level reviews into the Company's complaint record.

Contract Forms: The examiners identified seventeen (17) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, health plan description forms and riders/amendments/endorsements):

Issue E1: Failure to reflect that there is no age limit for the mandated coverage to be provided for treatment of cleft lip and/or cleft palate.

Issue E2: Failure to disclose the existence and availability of an access plan in health benefit plans.

Issue E3: Failure to reflect mandatory repair and replacement coverage to be provided for prosthetic devices.

Issue E4: Failure to specify the period to be used for mammogram coverage.

Issue E5: Failure to allow benefits for covered services based on a licensed provider's status as a member of the insured's family or having the same legal residence.

Issue E6: Failure to reflect accurate requirements to qualify as a dependent.

Issue E7: Failure to accurately reflect the coverage to be offered for Home Health Services and Hospice Care. (*This was prior issue E2 in the findings of the 2002 final examination report*.)

Issue E8: Failure to reflect correct coverage for court-ordered substance abuse treatment.

Issue E9: Failure to reflect the mandated minimum hours of hospital stay to be provided for normal and cesarean section deliveries.

Issue E10: Failure to utilize a fraud statement that is substantially the same as required by Colorado insurance law.

Issue E11: Failure to alert covered persons who may use out-of-network providers or covered persons under indemnity plans that providers are not prohibited from balance billing.

Issue E12: Failure to reflect correct procedures for adding benefits, making changes, modifications or withdrawals with amendments to the Basic and Standard Health Benefit Plans.

Issue E13: Failure to reflect completely the situations in which non-emergency care delivered in an emergency room would be covered.

Issue E14: Failure to reflect complete or correct benefit descriptions for mandated mental health services in the Standard Indemnity and PPO Health Benefit Plans.

Issue E15: Failure to reflect a complete description of mandatory coverage for child health supervision services.

Issue E16: Failure to reflect the correct format and/or benefits in the Basic and Standard Health Benefit Plan Description Forms.

Issue E17: Failure to include a disclosure regarding the mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers, and an understandable definition of eligible expenses as well as the methodology for determining the usual, customary and reasonable reimbursement rate.

Cancellations/Non-Renewals/Declinations: There were two (2) areas of concern identified during the review of the small group cancellation files.

Issue H1: Failure to reflect the required definition of a "Significant break in coverage" in certificates of creditable coverage.

Issue H2: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan.

Claims: The examiners identified four (4) areas of concern in their review of the claims handling practices of the Company:

Issue J1: Failure, in some instances, to accurately process claims.

Issue J2: Failure, in some instances to pay, deny or settle claims within the timeframes required by Colorado insurance law.

Issue J3: Failure, in some instances, to pay late payment interest and/or penalties.

Issue J4: Failure to correctly process claims for out-of-network services/treatment associated with services/treatment rendered at an in-network facility.

Utilization Review: The examiners identified five (5) areas of concern in their review of the Company's Utilization Review procedures:

Issue K1: Failure to provide correct information related to an insured's right to appeal adverse determinations.

Issue K2: Failure to provide written notification to a covered person of a review meeting within the required time frame.

Issue K3: Failure to provide the location of the review panel meeting and thereby discouraging the covered person from requesting a face-to-face meeting.

Issue K4: Failure to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.

Issue K5: Failure, in some cases, to send written notification of adverse retrospective determinations.

Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

UNITED HEALTHCARE INSURANCE COMPANY

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Certifying and using forms that do not comply with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (s) *Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates.* Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-3-1107, 10-3-1108, and 10-3-1109. [Emphasis added.]

An officer of the Company must certify compliance with Colorado Insurance law on all initial filings of policy forms and on the annual report of policy forms. It appears that the Company is not in compliance with Colorado insurance law in that not all forms that were certified and used by the Company in 2007 were in compliance with statutory mandates as evidenced by issues #E1 through #E20 of this examination report.

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all policy forms to be issued or delivered to Colorado residents comply with statutory mandates as required by Colorado insurance law.

Issue A2: Failure to provide correct form numbers for some forms reported on the Annual Report of Policy Forms as being in use during 2007.

Colorado Insurance Regulation 1-1-6, Concerning The Elements Of Certification For Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act", promulgated pursuant to §§ 10-1-109, 10-4-419, 10-4-633, 10-15-105 and 10-16-107.2 and 10-16-119, C.R.S., states:

Section 2. Background and Purpose

> The purpose of this regulation is to promulgate rules applicable to the filing of new policy forms, new policy form listings, annual reports of policy forms, and certifications of policy forms.

Section 3. Applicability and Scope

> This regulation applies to all insurers and other entities authorized to conduct business in Colorado which provide health coverages, …

Section 4. Definitions

> For the purposes of this regulation:
>
> D. "Annual Report for health coverage" shall mean *a list of all policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado,* including the titles of the programs or products affected by the forms. [Emphasis added.]

Section 5. Rules

> C. Not later than December 31 of each year, each entity providing health care coverages shall file an Annual Report of policy forms including a fully executed certificate of compliance. …

The Company was requested in the pre-exam request letter to provide a copy of the Annual Report of Certification of Forms filed with the Division for forms which were in use during the period of the examination. It does not appear that this Annual Report was correct as the form numbers reported were not updated on the Annual Report of Forms for the following Plans:

Form Name	Form Numbers Reflected
United Healthcare Options PPO Standard Health Benefit Plan for Colorado	STDPPO.01.CO (1-2004)

United Healthcare Options PPO Basic Health Benefit Plan for Colorado	BASPO.01.CO (1-2004)
United Healthcare Managed Indemnity Standard Health Benefit Plan for Colorado	STDMI.01.CO (1-2006)

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 1-1-6. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that the form numbers for all forms that were in use during the year are reflected correctly on its Annual Certification Report of Forms.

Issue A3: Failure, in some instances, to maintain records required for market conduct purposes.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of Section 10-1-109(1), C.R.S., states in part:

Section 4. Records Required For Market Conduct Purposes

A. *Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations*, including but not limited to, company operations and management, policyholder services, claim's practices, rating, *underwriting*, marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two prior calendar years. [Emphasis added.]

During the review of the new business application files, the Company was unable to provide ten (10) new business application files that had been selected for review.

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 1-1-7. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all records required for market conduct examination purposes are maintained in compliance with Colorado insurance law.

Issue A4: Failure to report to the Division the correct number of second level and independent external appeals requested and completed in 2007.

Section 10-16-113.7, C.R.S., Reporting the denial of benefits to the division – rule, states in part:

> Each carrier shall report the number and outcome of second-level internal appeals pursuant to section 10-16-113 to the division by February 1 of each year. On at least an annual basis, the division shall compile the information reported by each carrier along with the number and outcome of third-level external appeals of each health coverage plan and make such information available on the division website and for public inspection. The commissioner may specify the format in which the information shall be submitted by a carrier.

It does not appear that correct information as to the number of second-level internal appeals and the number of third-level external appeals was reported to the Division for 2007.

The information provided by the Company in response to a request for a list of all decisions made which involved appeals of adverse determinations at each level reflected:

Second-level appeals requested and completed in 2007:	75
External appeals requested and completed in 2007:	8
CEU:	3
UBH	2
Non-CEU	3

The information reported by the Company on its annual report reflected:

Second-level appeals received and completed in 2007:	69
External appeals requested and completed in 2007:	6

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-113.7, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that correct information regarding appeals is reflected in all required reports as required by Colorado insurance law.

CONSUMER COMPLAINTS

Issue C1: Failure to enter all written first level and second level reviews into the Company's complaint record.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (i) Failure to maintain complaint handling procedures: Failing of any insurer to maintain *a complete record of all the complaints which it has received* since the date of its last examination. [Emphasis added} This record shall indicate the total number of complaints, their classification by line of instance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this paragraph (i) *"Complaint" shall mean any written communication primarily expressing a grievance*. [Emphasis added.]

Colorado Insurance Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review And Denial Of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 10 First Level Review

> C. Pursuant to Section 10-3-1104(1)(i), C.R.S., *all written requests for a first level review must be entered into the carrier's complaint record*. [Emphasis added.]

Section 11 Voluntary Second Level Review

> C. A complaint record entry shall be made for all voluntary second level reviews, pursuant to Section 10-3-1104(1)(i), C.R.S., and Colorado Insurance Regulation 6-2-1. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that first and second level reviews involving behavioral health were not recorded in the Company's complaint record. Utilization review involving mental health services, including first and second level reviews are handled by United Behavioral Health (UBH). The Company provided data indicating that there were 123 first level reviews and twelve (12) voluntary second level reviews handled by UBH during the period under examination. However, none of these reviews handled by UBH were entered into the carrier's complaint records as required by Colorado insurance law.

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. and Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all written first and second level reviews are entered into the Company's complaint record in compliance with Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure to reflect that there is no age limit for the mandated coverage to be provided for treatment of cleft lip and/or cleft palate.

Section 10-16-104, C.R.S., Mandatory coverage provisions - definitions, states in part:

(1) Newborn children

(c)(II)(A) With regard to newborn children born with cleft lip or cleft palate or both, *there shall be no age limit on benefits for such conditions,* and care and treatment shall include to the extent medically necessary: Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; medically necessary orthodontic treatment; medically necessary prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment. [Emphasis added.]

(C) If a dental insurance policy, a contract for dental insurance, or an enrollee coverage contract issued pursuant to this article is in effect at the time of the birth, or is purchased after the birth, of a child with cleft lip or cleft palate or both, it shall provide fully for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both. …

It appears that the Company is not in compliance with Colorado insurance law in that the description in the *Section 1: What's Covered – Benefits* portion of the below forms does not reflect that there shall be no age limit on benefits for such conditions, and indicates that these benefits are provided only for an enrolled dependent child.

Each Certificate's definition of a dependent with regard to age is:

an unmarried dependent child who is 19 years of age or older, but less than 24 years of age and only if the child is a full-time student and financially dependent upon the subscriber or the subscriber's spouse.

Additionally, *the Section 1: What's Covered – Benefits* description of benefits in connection with cleft lip and/or cleft palate states that these benefits are provided only for a child who does not have a dental insurance policy or plan in effect at the time the services below are received. Colorado insurance law requires that an existing dental insurance policy or plan in effect at the time services are provided is only to provide fully for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both. The treatments mandated by law include some that do not appear to be orthodontic or dental care in nature and are required to be covered by this plan

The Company's PPO and Indemnity Plan certificates state in part:

4. **Cleft Lip and Cleft Palate Treatment**

Benefits for the following services provided to an Enrolled Dependent child in connection with cleft lip and/or cleft palate when provided by or under the direction of a Physician.

These Benefits are provided only for an Enrolled Dependent child who does not have a dental insurance policy or plan in effect at the time the services below are received.

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances, and feeding appliances.
- Otolaryngological services.
- Surgical management.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.

Form	Form Number
Managed Indemnity Certificate of Coverage (12-2003)	MICERT.I.01.CO
United HealthCare Options PPO Certificate of Coverage (12-2003)	PPO CERT I.01.CO

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its forms reflect the mandated coverage to be provided for treatment of children born with cleft lip and/or cleft palate as required by Colorado insurance law. The Company should also perform a self audit from January 1, 2007 to the present to identify and correct any claims for cleft lip and/or cleft palate that may have been inappropriately denied.

Issue E2: Failure to disclose the existence and availability of an access plan in health benefit plans.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

> (9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204(3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, *all health benefit plans* and marketing materials *shall clearly disclose the existence and availability of the access plan.* [Emphases added.]

It appears that the Company's certificate of coverage forms are not in compliance with Colorado insurance law in that they do not disclose the existence and availability of an access plan for its managed care networks.

Form	Form Number
Managed Indemnity Certificate of Coverage (12-2003)	MICERT.I.01.CO
United HealthCare Options PPO Certificate of Coverage (12-2003)	PPO CERT I.01.CO

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation why it should not be considered in violation of § 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all health benefit plan forms clearly disclose the existence and availability of an access plan as required by Colorado insurance law.

Issue E3: Failure to reflect mandatory repair and replacement coverage to be provided for prosthetic devices.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(14) Prosthetic devices

(a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, and 13951, and 1395m and 42 CFR 414.202, 414.210. 414.228 and 410.100, as applicable to this subsection (14).

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(c) *Repairs and replacements of prosthetic devices are also covered*, subject to copayments and deductibles, unless necessitated by misuse or loss. [Emphasis added.]

The description of coverage for prosthetic devices in the Company's certificates appears to be more limiting than the mandatory coverage required by Colorado insurance law in the following way:

- Coverage is limited to a single purchase of each type of prosthetic device every [two-five] [calendar] [policy] [years].

This does not allow for repairs and replacements of prosthetic devices when necessary as required by Colorado insurance law unless the repair or replacement is a result of misuse or loss.

The Company's PPO and Indemnity Plan certificates state:

20. Prosthetic Devices

Prosthetic devices that replace a limb or body part including:

- Artificial limbs.
- Artificial eyes.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every [[1]two-five] [calendar] [Policy] [[1] years] [[2]year]

Form Name	Form Number
Managed Indemnity Certificate of Coverage (12-2003)	MICERT.I.01.CO
United HealthCare Options PPO Certificate of Coverage (12-2003)	PPO CERT I.01.CO

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has corrected all applicable forms to reflect correct coverage for prosthetic devices as required by Colorado insurance law. The Company should also perform a self audit from January 1, 2007 to the date of the Final Agency Order and correct any claims for repairs or replacement of prosthetic devices that may have been incorrectly processed.

Issue E4: Failure to specify the period to be used for mammogram coverage.

Section 10-16-104., C.R.S., Mandatory coverage provisions – definitions, states in part:

(4) Low-dose mammography

(a) … Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, *which shall be specified in the policy or contract*. … [Emphasis added.]

The description of benefits to be provided for mammograms in the Company's certificates does not appear to be complete as required by Colorado insurance law in the following way:

- Nothing is reflected in the certificates to indicate whether annual screenings are to be provided on a calendar year or a contract year basis.

The certificates identified below reflect the following:

Benefits for mammograms include:

- A baseline mammogram for women 35 through 39 years of age.
- A mammogram every two years for women 40 through 49 years of age.
- An annual mammogram (and clinical breast examination) for women 50 years of age or older.

An annual mammogram (and clinical breast examination) for women 40 years or older who have risk factors, as determined by a Physician.

Form Name	Form Number
Managed Indemnity Certificate of Coverage Page 26	MICERT.I.01.CO (12-2003)
United HealthCare Options PPO Certificate of Coverage Pages 29 and 30	PPO CERT I.01.CO (12-2003)
United HealthCare Options PPO Standard Health Benefit Plan for Colorado Page 32	StdPPOCOC.I.01.CO

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has corrected all applicable forms to reflect a complete description of benefits to be provided for mammograms as required by Colorado insurance law.

Issue E5: Failure to allow benefits for covered services based on a licensed provider's status as a member of the insured's family or having the same legal residence.

Section 10-16-104., C.R.S., Mandatory coverage provisions – definitions, states in part:

(7) Reimbursement of providers.

(a) Sickness and accident insurance.

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, *whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed*. … [Emphasis added.]

The Company's certificates reflect an exclusion that does not appear to be in compliance with Colorado insurance law by excluding coverage for services performed by a provider who is a member of the insured's family, or who has the same legal residence as the insured. A policy may contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services; nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, (e.g., a family member by birth or marriage, or a provider with the same legal residence as the insured).

The Company's PPO and Indemnity Plan certificates state:

Section 2: What's Not Covered – Exclusions

L. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.

Form Name	Form Number
Managed Indemnity Certificate of Coverage (12-2003)	MICERT.I.01.CO
United HealthCare Options PPO Certificate of Coverage (12-2003)	PPO CERT I.01.CO
United Healthcare Managed Indemnity Standard Health Benefit Conversion Policy	StdMIConv.I.01.CO

United Healthcare Managed Indemnity Basic Limited Mandate Health Benefit Plan for Colorado	BASMI.01.CO (1-2006)
United Healthcare Managed Indemnity Standard Health Benefit Plan for Colorado	STDMI.01.CO (1-2006)
United Healthcare Options PPO Basic Limited Mandate Health Benefit Plan for Colorado	BasPPOCOC.I.01.CO
United Healthcare Options PPO Standard Health Benefit Plan for Colorado	StdPPOCOC.I.01.CO

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that reimbursement for covered services provided by a licensed provider is not denied based solely upon the provider's status as a family member or because the provider lives at the same address as the insured. The Company should also perform a self audit from January 1, 2007 to the date of the Final Agency Order and correct any claims for eligible providers that may have been incorrectly denied.

Issue E6: Failure to reflect accurate requirements to qualify as a dependent.

Section 10-16-102, C.R.S., Definitions, states in part:

> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part

> (6) Dependent children.
>
> (b) No entity described in paragraph (a) of this subsection (6) *shall refuse to provide coverage for a dependent child* under the health plan of the child's parent for the sole reason that the child:
>
> (I) *Does not live in the home* of the parent applying for this policy; or
>
> (II) *Does not live in the insurer's service area*, notwithstanding any other provision of law restricting enrollment to persons who reside in an insurer's service area; [Emphases added.]

The Company's Certificates of Coverage and Amendments to the Policy and Certificates of Coverage identified below do not appear to reflect accurate requirements for qualifying as a dependent in that they include the requirements that a child:

a) reside within the Service area, or
b) reside with the Subscriber who lives within the service area, or
c) have the same legal residence as the Subscriber.

Form Name	Form Number
Managed Indemnity Certificate of Coverage (12-2003)	MICERT.I.01.CO
Amendment to Your Certificate of Coverage P.01.CO	RPAMD.CMS.I-
United HealthCare Options PPO Certificate of Coverage (12-2003)	PPO CERT I.01.CO
Amendment to Your Certificate of Coverage P.01.CO	RPAMD.CMS.I-
United Healthcare Managed Indemnity Standard Health Benefit Conversion Policy	StdMIConv.I.01.CO

(Company using Managed Indemnity Standard Health Benefit Plan for Colorado as Conversion Plan)	
United Healthcare Managed Indemnity Basic Limited Mandate Health Benefit Plan for Colorado	BASMI.01CO (1-2006)
United Healthcare Managed Indemnity Standard Health Benefit Plan for Colorado	STDMI.01.CO (1-2006)
Amendment to Your Gen.I.01.C0 Certificate of Coverage	DCHILDAmd-Age25-
Amendment to the Policy and Certificates of Coverage	DChildAmd-Age25.I.01.CO
United Healthcare Options PPO Standard Health Benefit Plan for Colorado	StdPPOCOC.I.01.CO
United Healthcare Options PPO Basic Limited Mandate Health Benefit Plan for Colorado	BasPPOCOC.I.01.CO

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation why it should not be considered in violation of §§ 10-16-102 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has corrected all applicable forms to reflect accurate requirements to qualify as a dependent as required by Colorado insurance law.

Issue E7: Failure to accurately reflect the coverage to be offered for Home Health Services and Hospice Care. (*This was prior issue E2 in the findings of the 2002 final examination report*.)

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(8) Availability of hospice care coverage

(a) As used in this subsection (8), unless the context otherwise requires:

(I) "Home health services" means home health services as defined in section 25.5-4-103 (7) C.R.S., which are provided by a home health agency certified by the department of public health and environment.

(II) "Hospice care" means hospice services provided to a terminally ill individual by a hospice care program, licensed and regulated by the department of public health and environment pursuant to sections 25-1.5-103(1)(a) (I) and 25-3-101, C.R.S., or by others under arrangements made by such hospice care program.

(d) The Commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions *which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care.* [Emphasis added.] Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

+

Colorado Insurance Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d), Colorado Revised Statutes (C.R.S.) states in part:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state clearly and completely the criteria for and extent of coverage for home health services and hospice care and to facilitate prompt and informed decisions regarding patient placement and discharge.

Section 4. Requirements for Home Health Services

A. Definitions.

(2) "Home health services" means the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:

(b) *Certified nurse aide services*, as defined in §12-38.1-102(3). C.R.S.:

(c) Medical supplies, equipment and appliances suitable for use in the home; and

(d) Physical therapy, occupational therapy or speech pathology and audiology services, as such therapy and services are defined in C.R.S. [Emphases added.]

(4) "*Medical social services*" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.

B. General Policy Provisions Pertaining to Home Health Care.

(1) The policy offering shall provide that home health services are to be *covered when such services are necessary as alternatives to hospitalization or in place of hospitalization*. Prior hospitalization shall not be required.

C. Benefits for Home Health Care Services.

(3) The policy offered shall include benefits for the following services:

(a) *Certified nurse aide services* under the supervision of a Registered Nurse or a qualified therapist;

(b) Physical Therapy;

(c) Occupational Therapy;

(d) Speech therapy and audiology;

(e) Respiratory and inhalation therapy;

(f) Nutrition counseling by a nutritionist or dietitian;

(h) Medical social services;

Section 5. Requirements for Hospice Care

A. Definitions.

(1) …Hospice services shall be provided in the home, a licensed hospice, and/or other licensed health facility. Hospice services include but shall not necessarily be limited to the following: *nursing*, physician, *certified nurse aide, nursing services delegated to other assistants, homemaker,* physical therapy, pastoral counseling, *trained volunteer,* and social services. [Emphasis added.]

(12) "Home care services" are hospice services, *which are provided in the place the patient designates as his/her primary residence which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility*. [Emphasis added.]

(20) An "unrelated illness" is a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness.

B. General Provisions Pertaining to Hospice Care

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. *After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.* [Emphasis added.]

(5) The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

C. Benefits for Hospice Care Services.

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day for any combination of the following routine home care services*, which are planned, implemented and evaluated by the interdisciplinary team: [Emphasis added.]

(a) Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;

(b) Intermittent and 24 hour on-call social/counseling services; and;

(c) Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days. [Emphasis added.]

(3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, *which are exclusive of and shall not be included in the dollar limitation for hospice*

care benefits as specified in (2) above:

(a) Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1150.

(c) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(d) Medical supplies;

(e) Drugs and biological;
(f) Prosthesis and orthopedic appliances;

(g) Oxygen and respiratory supplies;

(h) Diagnostic testing;

(i) Rental or purchase of durable equipment;

(j) Transportation;

(k) Physicians services;

(l) Therapies including physical, occupational and speech; and

(m) Nutritional counseling by a nutritionist or dietitian. [Emphases added.]

The Company's certificates for the two (2) most commonly sold plans during the period under examination do not appear to reflect correctly and completely the extent of coverage to be offered for home health services and hospice care in the following ways:

HOME HEALTH CARE

<u>This part of the company's certificates are incomplete:</u>

- Nothing is reflected to specify that services provided by a Certified Nurse Aid are included as Home Health Care services to be provided.

- Nothing is reflected to specify that physical, occupational, speech therapy and audiology are services for which Home Health benefits are provided.

- Nothing is reflected to indicate that "medical social services" are included in Home Health Care as covered benefits.

- Nothing is reflected to specify that "orthopedic appliances" are covered Home Health Care benefits.

The Company's PPO and Indemnity Plan certificates and amendments state:

> Section 1: What's Covered – Benefits
>
> 10. Home Health Care
>
> Services received from a Home Health Agency that are both of the following:
>
> - Ordered by a Physician.
>
> - Provided by or supervised by a registered nurse in your home.
>
> Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
>
> - It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
> - It is ordered by a Physician.
> - It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair.
>
> - It requires clinical training in order to be delivered safely and effectively.
>
> - It is not Custodial Care.
>
> We will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

HOSPICE CARE

<u>This part of the company's certificates are incorrect:</u>

There are notes under the description of covered health services that indicate a group may choose to limit benefits by one-half or 50%. Colorado insurance law does not prohibit an insurer from offering a higher level of benefits than what is required by law, but there is no provision for offering a lesser level of benefits.

<u>This part of the company's certificates are incomplete:</u>

- Nothing is reflected concerning the fact that "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

- Nothing is reflected to specify that nursing, certified nurse aide, nursing services delegated to other assistants, homemaker, or trained volunteer are included in hospice services to be provided.

- Nothing is reflected to indicate that after the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's medical director to determine the appropriateness of continuing hospice care.

- Nothing is reflected to indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

- The amendment for the Company's plans indicate that notification for non-network services is to be provided five (5) business days before receiving services or benefits will be reduced to [25-50%] of eligible expenses. Nothing is reflected concerning the fact that for emergencies, weekends or holidays, the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day.

- Nothing is reflected to identify the twelve (12) benefits which are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

The Company's Indemnity Plan certificate states:

Section 1: What's Covered -- Benefits
Section 11. Hospice Care
Column titled: "Your Copayment Amount" **[**$[0-100] [per day**]** & **[**[0-50]**%**]
Group [text] [1] When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the benefit level (i.e., if the copayment is 20%, the benefit level is 80% and the number to insert here is 40%)
Group [text] [2] When the benefit plan design is to reduce benefit to 50%, insert 50%

The Amendment for this Indemnity Plan and the PPO Plan states:

Column titled: "Must You Notify Us? Yes for Non-Network
Group [text] [1] When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the benefit level (i.e., if the copayment is 20%, the benefit level is 80% and the number to insert here is 40%)
Group [text] [2] When the benefit plan design is to reduce benefit to 50%, insert 50%

Notify Us

Please remember that you should notify us five business days before receiving services. For Non-Network, if you don't notify us, Benefits will be reduced to [[1-2] 25-50%] of Eligible Expenses.

The Company's PPO Plan certificate states:

Section 1: What's Covered -- Benefits
Section 11. Hospice Care
Column titled: "Your Copayment Amount" Network **[**$[0-100] [per day**]**
Non-Network **[**[0-50]**%**]

Form Name	Form Number
Managed Indemnity Certificate of Coverage	MICERT.I.01.CO (12-2003)
Amendment to Your Certificate of Coverage	MandatedBenefits.I.01.CO
United HealthCare Options PPO Certificate of Coverage	PPO CERT I.01.CO (12-2003)
Amendment to Your Certificate of Coverage	MandatedBenefits.I.01.CO
United Healthcare Options PPO Standard Health Benefit Plan For Colorado	StdPPOCOC.I.01.CO

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that the required coverage to be offered for home health services and hospice care is accurately reflected in all its policies and certificate forms as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 2002 through December 31, 2002, the Company was cited for failure to provide a complete and accurate description of the required Hospice Care benefits. The violation resulted in Recommendation #2; that the Company revise all affected forms to reflect the correct Hospice Care benefits as mandated by Colorado insurance law. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of § 10-1-205, C.R.S.

Issue E8: Failure to reflect correct coverage for court-ordered substance abuse treatment.

Section 10-16-104.7., C.R.S., Substance abuse – court-ordered treatment coverage, states in part:

> (1) Any individual or group health benefit plan delivered or issued for delivery within this state by an entity subject to the provisions of part 2, 3, or 4 of this article *that provides coverage for substance abuse treatment shall provide coverage for substance abuse treatment regardless of whether the treatment is voluntary or court-ordered as a result of contact with the criminal justice or legal system.* The health benefit plan shall only be required to provide coverage for benefits that are medically necessary and otherwise covered under the plan. Such coverage shall be subject to copayment, deductible, and policy maximums and limitations. …[Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its certificates of coverage exclude coverage for treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements involving treatment for substance abuse unless authorized by the Mental Health/Substance Abuse Designee. This language implies that coverage for substance abuse under any of these circumstances is excluded unless authorized on an exception basis. Coverage for substance abuse is to be provided when medically necessary regardless of whether the treatment is voluntary or court-ordered as a result of contact with the criminal justice or legal system.

The Company's PPO and Indemnity Plan certificates state in part:

> Section 2: What's Not Covered – Exclusions
>
> H. Mental Health/Substance Abuse 6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.

Form Name	Form Number
Managed Indemnity Certificate of Coverage (12-2003)	MICERT.I.01.CO
United HealthCare Options PPO Certificate of Coverage (12-2003)	PPO CERT I.01.CO

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104.7, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has corrected all applicable forms to ensure that coverage for substance abuse treatment is provided when medically necessary, regardless of whether the treatment is voluntary or court-ordered as a result of contact with the criminal justice or legal system, in compliance with Colorado insurance law.

Issue E9: Failure to reflect the mandated minimum hours of hospital stay to be provided for normal and cesarean section deliveries.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn Children

(b)(I) Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. *If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.*

(II) Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. *If ninety-six hours following the cesarean section falls after 8:00 p.m., coverage shall continue until 8 a.m. the following morning.* [Emphases added.]

(3) Maternity coverage

(II) Coverage for a hospital stay following a normal vaginal delivery shall not be limited to less than forty-eight hours. *If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning*.

(III) Coverage for a hospital stay following a cesarean section shall not be limited to less than ninety-six hours. *If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning. [Emphases added.]*

It appears that the Company is not in compliance with Colorado insurance law in that its Certificates and Amendments identified below reflect an incomplete description of the mandated minimum hours of coverage to be allowed for in-patient maternity and newborn services by failing to reflect that if the forty-eight or ninety-six hour minimum coverage falls after 8:00 p.m. the in-patient benefits will be covered until 8 a.m. the following morning.

The following language is reflected on the certificates and page numbers identified below:

14. Maternity Services

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

Form Name	Form Number
Managed Indemnity Certificate of Coverage	MICERT.I.01.CO (12-2003)
Amendment to Your Certificate of Coverage	RPAMD.CMS.I-P.01.CO

United HealthCare Options PPO Certificate of Coverage	PPO CERT I.01.CO (12-2003)
Amendment to Your Certificate of Coverage	RPAMD.CMS.I-P.01.CO
United Healthcare Managed Indemnity Standard Health Benefit Conversion Policy (Company using Managed Indemnity Standard Health Benefit Plan for Colorado as Conversion Plan)	StdMIConv.I.01.CO
United Healthcare Managed Indemnity Basic Limited Mandate Health Benefit Plan for Colorado	BASMI.01CO (1-2006)
United Healthcare Managed Indemnity Standard Health Benefit Plan for Colorado	STDMI.01.CO (1-2006)
United Healthcare Options PPO Standard Health Benefit Plan for Colorado	StdPPOCOC.I.01.CO
United Healthcare Options PPO Basic Limited Mandate Health Benefit Plan for Colorado	BasPPOCOC.I.01.CO

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to correctly reflect the mandated minimum hours of hospital stay to be provided for normal and cesarean section deliveries.

Issue E10: Failure to utilize a fraud statement that is substantially the same as required by Colorado insurance law.

Section 10-1-128, C.R.S., Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration, states in part:

> (6)(a) Each insurance company shall provide on all printed applications for insurance, or on all insurance policies, or on all claim forms provided and required by an insurance company, or required by law, whether printed or electronically transmitted, a statement, in conspicuous nature, permanently affixed to the application, insurance policy, or claim form *substantially the same as the following*: [Emphasis added.]
>
> **It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.**

The Company's application forms reflect a fraud statement that does not appear to be in compliance with Colorado insurance law as the wording is not substantially the same as reflected in the law.

The applications all reflect the following wording:

> Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Form Name	Form Number
Key Account Insured Employer Application (Large Group)	380-1475 2/03
Conversion Renewal Application	RCONVAPP.I.01.CO
Application For Conversion Of Group Coverage	GCAPP.I.01.CO
Application For Conversion Of Group Coverage	GCAP.I.01.CO 12/2005

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-1-128, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised the fraud statement to be substantially the same as what is required by Colorado insurance law.

Issue E11: Failure to alert covered persons who may use out-of-network providers or covered persons under indemnity plans that providers are not prohibited from balance billing.

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2 Background and Purpose

> The purpose of this amendment to Colorado Insurance Regulation 4-6-5 is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard plans and to incorporate other changes necessary for compliance with Colorado law. This regulation specifies the requirements for the basic and standard health benefit plans.
>
> BASIC AND STANDARD HEALTH BENEFIT PLAN
> POLICY REQUIREMENTS FOR THE STATE OF COLORADO
>
> Colorado Division of Insurance
> January 1, 2006
>
> 5. All basic and standard health benefit plans shall also comply with the following requirements:
>
> A. Balance Billing: In-network preferred providers and HMO providers are prohibited from balance billing individuals insured under the basic or standard health benefit plan. "Balance billing" refers to the practice whereby a provider bills an individual covered under the basic or standard health benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the services delivered.
>
> *In the case of indemnity plans and out-of-network preferred provider plan benefits, carriers must alert those covered under the basic and standard health benefit plans to the fact that their provider is not prohibited from balance billing except as proscribed in § 10-16-704, C.R.S.* Consumers should be encouraged to discuss the issue with their provider. [Emphasis added.]

The Company's Basic and Standard plans do not appear to be complete in that there is no notification included in the plans to alert covered persons that when using out-of-network preferred providers, in the case of indemnity plans, that their provider is not prohibited from balance billing except as proscribed in § 10-16-704, C.R.S.

Form Name	Form Number
United Healthcare Managed Indemnity Standard Health Benefit Conversion Policy	StdMIConv.I.01.CO

United Healthcare Managed Indemnity Standard Health Benefit Plan for Colorado	STDMI.01.CO (1-2006)
United Healthcare Options PPO Basic Health Benefit Plan for Colorado	BASPPO.01.CO (1-2004)
United Healthcare Options PPO Standard Health Benefit Plan for Colorado	STDPPO.01.CO (1-2004)

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its Basic and Standard Health Benefit Plans alert covered persons that when using out-of-network preferred providers, or in the case of persons covered under indemnity plans, that their provider is not prohibited from balance billing except as proscribed in § 10-16-704, C.R.S.

Issue E12: Failure to reflect correct procedures for adding benefits, making changes, modifications or withdrawals with amendments to the Basic and Standard Health Benefit Plans.

Colorado Insurance Regulation 4-6-5, Concerning The Basic And Standard Health Benefit Plans, promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Section 2. Background and Purpose

The purpose of this amendment to Colorado Insurance Regulation 4-6-5 is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard plans and to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans*. [Emphasis added.]

Section 3 Applicability and Scope

This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S. and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

5. All basic and standard health benefit plans shall also comply with the following requirements:

B. Benefit Modifications: The form and level of coverages specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" *may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only*. [Emphasis added.]

The Company's Basic PPO Limited Mandate Health Benefit Plan and Standard PPO Health Benefit Plan, both marketed in Colorado, each indicate that the Company may add benefits via an amendment to the policy at its sole discretion. This appears to be contradictory to the regulation which specifically indicates that these plans may add additional coverage through a rider or endorsement only at the option of the policyholder. Additionally, the benefits to be provided by these plans is determined by the Regulation and may not be changed or modified at the Company's discretion.

The Company's Basic and Standard PPO and Managed Indemnity plans state:

> Section 9: General Legal Provision
>
> Amendments to the Policy
>
> To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy. …

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised the language regarding amendments to the Basic and Standard plans to ensure compliance with Colorado insurance law.

Issue E13: Failure to reflect completely the situations in which non-emergency care delivered in an emergency room would be covered.

Colorado Insurance Regulation 4-6-5, Concerning The Basic And Standard Health Benefit Plans, promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Section 2. Background and Purpose

> The purpose of this amendment to Colorado Insurance Regulation 4-6-5 is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard plans and to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans*. [Emphasis added.]

Section 3 Applicability and Scope

> This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S. and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled “Basic Limited Mandate Health Benefit Plan”, Basic HSA Health Benefit Plan”, or “Basic HAS Limited Mandate Health Benefit Plan”.

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled “Standard Health Benefit Plan”.

Benefit Grid

JANUARY 1, 2006 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:
IDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

15. EMERGENCY CARE [12, 13]

Footnotes: 13 Non-emergency care delivered in an emergency room *is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier* or primary care physician. … [Emphasis added.]

The language reflected in the Company's Basic and Standard Indemnity and PPO Health Benefit Plans does not describe completely the situations in which non-emergency care delivered in an emergency room would be covered. It does not indicate that this care is to be covered if the covered person was referred to the emergency room by his/her carrier.

Form Number: BasPPOCOC.I.01.CO. the Company's Basic PPO Limited Mandate Health Benefit Plan certificate, states on Pages 16 and 17: (see below)

Form Number: StdPPOCOC.I.01.CO, the Company's Standard PPO Health Benefit Plan certificate. states on Pages 18 and 19: (see below)

Form Number: BASMI.01.CO (1-2006), the Company's Managed Indemnity Basic Limited Mandate Health Benefit Plan certificate, states on Pages 16 and 17: (see below)

Form Number: STDMI.01.CO (1-2006), the Company's Managed Indemnity Standard Health Benefit Plan certificate, states on Pages 17 and 18:

> 6. Emergency Health Services
> (Standard Indemnity Plans reflect 7. Emergency Health Services)
>
> Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.
>
> Non-emergency care delivered in an emergency room *is covered only if you were referred by a Network Physician to the emergency room for care.* [Emphasis added.]
> …
> (Standard Indemnity Plan reflects "Physician" not "Network Physician"

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised the language regarding coverage for non-emergency care delivered in an emergency room to comply with Colorado insurance law.

Issue E14: Failure to reflect complete or correct benefit descriptions for mandated mental health services in the Standard Indemnity and PPO Health Benefit Plans.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

> (5) Mental Illness. Every group policy or contract providing hospitalization or medical benefits by an entity subject to the provisions of part 2 or 3 of this article *shall provide benefits for conditions arising from mental illness at least equal to the following*:
>
> (a) In the case of basic coverage benefits based upon either confinement as an inpatient or partial hospitalization in a hospital or psychiatric hospital licensed by the department of public health and environment, *the period of confinement for which benefits are payable shall be at least forty-five days for inpatient care or ninety days for partial hospitalization in any one twelve-month-benefit period.* For the purpose of computing the period for which benefits are payable, *each two days of partial hospitalization care shall reduce by one day the forty-five days available for inpatient care, and each day of inpatient care shall reduce by two days the ninety days available for partial hospitalization care. Each day of confinement as an inpatient or each two days of partial hospitalization shall reduce by one day the total days available for all other illnesses during any one twelve-month-benefit period.* [Emphases added.]

Colorado Insurance Regulation 4-6-5, Concerning The Basic And Standard Health Benefit Plans, promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105 (7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2. Background and Purpose

> The purpose of this amendment to Colorado Insurance Regulation 4-6-5 is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard plans and to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans*. [Emphasis added.]

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

> 2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled* "Standard Health Benefit Plan". [Emphasis added.]
>
> 3. All provision of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

Benefit Grid

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

	STANDARD INDEMNITY PLAN	STANDARD PREFERRED PROVIDER PLAN	
		IN-NETWORK	OUT-OF-NETWORK
19. Other Mental Health Care [17] a) Inpatient Care [16] *b) Outpatient Care*	50% coinsurance Maximum 45 inpatient or 90 partial days/year	50% coinsurance Maximum 45 inpatient or 90 partial days/year	

Footnote 16: The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

The Company's Managed Indemnity Standard Health Benefit Plan and United Healthcare Options PPO Standard Health Benefit Plan do not appear to be in compliance with Colorado insurance law in that they do not reflect complete or correct benefit descriptions for Mental Health Services – Inpatient and Intermediate Care in the following ways:

<u>This part of the company's plans are incomplete:</u>

- There is nothing reflected concerning the provision that the day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

<u>This part of the company's plans are incorrect:</u>

- The benefit provision that two sessions of intermediate/partial hospitalization may be substituted for one inpatient day is determined by Colorado insurance law and not at the discretion of the Company's Designee.

The following language is reflected in the certificates identified below:

16. Mental Health Services – Inpatient and Intermediate

The Mental Health/Substance Abuse Designee, who will arrange for the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-Private Room basis. *At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. …* [Emphasis added.]

Form Name	Form Number
United Healthcare Options PPO Standard Health Benefit Plan for Colorado	StdPPOCOC.I.01.CO
United Healthcare Managed Indemnity Standard Health Benefit Plan for Colorado (Colorado Mandated Standard Indemnity Health Plan)	STDMI.01.C0 (1-2006)

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable policies to reflect complete and correct benefits for mental health services, in compliance with Colorado insurance law.

Issue E15: Failure to reflect a complete description of mandatory coverage for child health supervision services.

Section 10-16-104., C.R.S., Mandatory coverage provisions – definitions, states in part:

(11) Child health supervision services

(a) For purposes of this subsection (11), unless the context otherwise requires, "*child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2),* to dependent children up to age thirteen. Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Attachment 1

Covered Preventive Services [1]	
All children	**mmunizations.** ***Immunization deficient children are not bound by "recommended ages".*** **Emphasis added.]**

The benefits for Child Health Supervision Services that are reflected in the Certificates of Coverage for the six (6) plans identified below appear to reflect an incomplete description of the mandated benefits as nothing is reflected to alert insureds that immunization deficient children are not bound by the recommended ages on the immunization chart.

The following language is reflected on the certificates identified below:

Section 1: What's Covered – Benefits

18. Physician's Office Services

Covered Health Services received in a Physician's office including: …

- Immunizations.

State Mandate

- Child Health Supervision Services

Section 10: Glossary of Defined Terms

Child Health Supervision Services – those preventive services and immunizations required to be provided to dependent children up to age 13 as follows:

- All Children: Immunizations.

Section 1: What's Covered - Benefits

15. Physician's Office Services (UHC Options PPO Basic Limited Mandate HBP certificate)

18. Physician's Office Services
Covered Health Services for preventive medical care. Preventive medical care includes:

- Immunizations as recommended by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. This includes chicken pox vaccinations for Covered Persons who have not had chicken pox.

Form Name	Form Number
Managed Indemnity Certificate of Coverage (12-2003)	MICERT.I.01.CO
United Healthcare Options PPO Certificate of Coverage	PPOCERT I.01.CO (12-2003)
United Healthcare Managed Indemnity Standard Health Benefit Plan for Colorado	STDMI.01.CO (1-2006)
United Healthcare Options PPO Standard Health Benefit Plan for Colorado	StdPPOCOC.I.01.CO
United Healthcare Managed Indemnity Basic Limited Mandate HBP	BASMI.01.CO (1-2006)
United Healthcare Options PPO Basic Limited Mandate HBP	BasPPOCOC.I.01.CO

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect complete descriptions of the mandated child health supervision services as required by Colorado insurance law. The company should also conduct a self audit to determine whether any claims were improperly denied for immunization deficient children outside of the age limits indicated on the plans, and reprocess any such claims in accordance with the regulatory requirements.

Issue E16: Failure to reflect the correct format and/or benefits in the Basic and Standard Health Benefit Plan Description Forms.

Colorado Insurance Regulation 4-2-20, Concerning the Colorado Health Benefit Plan Description Form, promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 10-16-108.5(11)(b), and 10-16-109, C.R.S., states in part:

Section 3. Applicability

This amended regulation shall apply to all carriers offering or providing health benefit plan coverage or Medicare supplemental coverage on and after July 1, 2007.

Section 4. Rules

C. *Carriers shall use the exact format found in Appendix A for the Colorado Health Benefit Plan Description Form, including all headings, notes, row numbers and footnotes*. … [Emphasis added.]

Section 7. Effective Date

This amended regulation is effective on July 1, 2007.

Colorado Insurance Regulation 4-6-5, Concerning The Basic And Standard Health Benefit Plans, promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8) and 10-16-109, C.R.S.

Basic And Standard Health Benefit Plan
Policy Requirements For The State of Colorado

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

The Colorado Health Benefit Plan Description Forms (HPDFs) provided by the Company as being used for the its Basic and Standard Health Benefit Plans do not appear to have been in compliance with Colorado insurance law with regards to required format or benefits from 7/1/07 to 4/1/08. The HPDFs for the Basic and Standard plans had not been updated to reflect the changes that resulted when Colorado Insurance Regulation 4-6-5 was amended effective 7/1/07. As a result, the format and some of the benefits reflected in the HPDFs were incorrect until they were updated by the Company on 4/1/08.

Form Name	Form Number
Colorado Health Benefit Plan Description Form	CORKMCOV02

(Standard Ind Plan)

Colorado Health Benefit Plan Description Form (Basic Ind Plan)	CORKMCOU02
Colorado Health Plan Description Form Standard Preferred Provider Plan CO-T	CORJMCOT02
Colorado Health Benefit Plan Description Form (Basic PPO Plan)	CORJMCOS02

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulations 4-2-20 and 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all its Colorado Health Benefit Plan Description Forms are in compliance with Colorado insurance law.

Issue E17: Failure to include a disclosure regarding the mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers, and an understandable definition of eligible expenses as well as the methodology for determining the usual, customary and reasonable reimbursement rate.

Section 10-3-1104, C.R.S., Unfair method of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(b) False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading;

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration – repeal, states in part:

(2)(d) *The carrier shall provide, in conspicuous, bold-faced type, an understandable disclosure in policy contract materials, certificates of coverage for a policyholder, and marketing materials about the following:*

(III) *The mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers for specific covered health care services.*

(e)(I) A carrier shall make available upon request from the covered person or the nonparticipating provider, from whom the covered person is seeking treatment, the carrier's usual, customary, and reasonable rate for reimbursement for specific health care services.

(III) *The carrier's methodology for determining usual, customary, and reasonable reimbursement rates shall be applied in a uniform manner statewide; except that geographic adjustments may be made apart from the standard methodology.*

(f) For the purposes of this subsection (2):

(III) *"Usual, customary, and reasonable rate" means a rate established pursuant to an appropriate methodology that is based on generally accepted industry standards and practices.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms failed to include in conspicuous, bold-faced type, an understandable disclosure regarding the mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers. In addition, the definition of eligible expenses as set forth in each of the reviewed policy forms does not provide sufficient information for the member to determine potential liability for non-network claims nor does it provide sufficient

information for the member to determine if the non-network claim was correctly processed.

The cited definitions set forth four (4) or more criteria under which the Company, *at its discretion*, will determine the amount payable for non-network claims. This does not appear to comply with the requirement that the carrier establish its "usual, customary, and reasonable reimbursement rates in a uniform manner based on generally accepted industry standards and practices."

The Company's definition for eligible expenses for its *Options PPO Standard Health Benefit Plan for Colorado* [Form, StdPPOCOC.I.01.CO] and its *Options PPO Basic Limited Mandate Health Benefit Plan for Colorado* [Form, BasPPOCOC.I.01.CO] plan is as follows:

> **Eligible Expenses** - for Covered Health Services incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below:
>
> For Network Benefits, Eligible Expenses are based on either of the following:
>
> - When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
>
> - When Covered Health Services are received from non-Network providers, Eligible Expenses are billed charges unless a lower amount is negotiated.
>
> For Non-Network Benefits, Eligible Expenses are based on either of the following:
>
> Administrative [text] Include the provisions that apply for determining Eligible Expenses for Non-Network Benefits.
>
> - When Covered Health Services are received from non-Network providers, Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:
> -[Available data resources of competitive fees in that geographic area.]
> -[Our most commonly used contracted fee(s) with Network providers for the same or similar service within the geographic market] [or] [the amount determined by us which Network providers have agreed to accept as payment in full.]
> - [Fee(s) that are negotiated with the provider.]
> - [[A percentage][___%] of the published rates allowed by Medicare for the same or similar service [within the geographic market.
> - [[A percentage][___%] of the published rates allowed by CMS for the same or similar service [within the geographic market].]
> - [[A percentage][___%] of the published rates allowed by Medicare [in [name of county, name of state]] for the same or similar service.]
> - [[A percentage][___%] of the published rates allowed by CMS [in [name of county, name of state]] for the same or similar service.]
> - [__% of the billed charge.]
> - [A fee schedule that we develop.]
>
> - When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
>
> Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our

discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

The Company's definition for eligible expenses for its *Managed Indemnity Basic Limited Mandate Health Benefit Plan for Colorado* [Form, BASMI.01.CO(1-2006)] plan is as follows:

Eligible Expenses – the amount we will pay for Covered Health Services incurred while the Policy is in effect, are determined as stated below:

Administrative [text] Include the provisions that apply for determining Eligible Expenses.

- Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:
  - [Available data resources of competitive fees in that geographic area.]
  - [Our most commonly used contracted fee(s) with Network providers for the same or similar service within the geographic market] [or] [the amount determined by us which Network providers have agreed to accept as payment in full.]
  - [Fee(s) that are negotiated with the provider.]
  - [[A percentage][50-250%] of the published rates allowed by Medicare for the same or similar service [within the geographic market.
  - [[A percentage][50-250%] of the published rates allowed by CMS for the same or similar service [within the geographic market].]
  - [[A percentage][50-250%] of the published rates allowed by Medicare [in [name of county, name of state]] for the same or similar service.]
  - [[A percentage][50-250%] of the published rates allowed by CMS [in [name of county, name of state]] for the same or similar service.]
  - [__% of the billed charge.]
  - [A fee schedule that we develop.]

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

The Company's definition for eligible expenses for its *Options PPO, Certificate of Coverage,* [Form, PPOCERT.I.01.CO (12-2003)] plan is as follows:

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:
Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers, we calculate Eligible Expenses based on available data resources of competitive fees in that geographic area, unless you received services as a result of an Emergency or as otherwise arranged by us. In this case, Eligible Expenses are the fee(s) that we negotiate with the non-Network provider.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

The Company's definition for eligible expenses for its *Managed Indemnity, Certificate of Coverage,* [Form, MICERT.I.01.CO (12-2003)] plan is as follows:

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

Eligible Expenses are based on available data resources of competitive fees in that geographic area.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has included in conspicuous, bold-faced type, an understandable disclosure regarding the mechanisms to obtain the carrier's reimbursement rates to nonparticipating providers, and corrected the definition of eligible expenses as well as the methodology for determining the usual, customary and reasonable reimbursement rate, in order to comply with Colorado insurance law.

CANCELLATIONS/NON-RENEWALS/DECLINATIONS

Issue H1: Failure to reflect the required definition of a "Significant break in coverage" in certificates of creditable coverage.

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.* [Emphasis added.]

B. Colorado law concerning creditable coverage.

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, *any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation*. [Emphasis added.]

The Company provided Certificates of Creditable Coverage (COCC) for an initially designated eleven (11) small group terminated sample files. None of these COCC forms reflected the definition of "significant break in coverage" required by Colorado insurance law. The Company responded to an examiner's inquiry that its COCC forms are universal and the same for all groups and members that have terminated coverage with the Company, indicating all small group terminated sample files for which these forms were required, (105) failed to include the required definition of a "significant break in coverage" in the COCC forms. Eight (8) of these sample files would not have required that COCC forms be issued and therefore were not included as cited files.

Form Name	Form Number
Certification of Prior Creditable Coverage	5342FEDL Rev 07/21/08 071203
UHC Choice Plus Plan Certification Of Coverage	5348FEDR Rev 02/06/07 071203

Statement of HIPAA Portability Rights None

SMALL GROUP TERMINATED FILE SAMPLE

Population	Sample	Number of Exceptions	Percentage of sample
1,821	113	105	93%

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all Certificates of Creditable Coverage reflect the definition of a "Significant break in coverage" in compliance with Colorado insurance law.

Issue H2: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan.

Section 10-16-108(4), C.R.S., Conversion and continuation privileges, states in part:

(4) Special provisions for small group health benefit plans

(a) Effective January 1, 1995, each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.

(c) Each small employer carrier shall offer the choice of a basic or standard health benefit plan to any individual who loses nexus to existing small group coverage; except that:

(I) If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of this paragraph (c) shall not apply to such an individual; and

(II) If an individual lost nexus to group coverage for fraud or abuse in procuring or utilizing coverage, then the provisions of this paragraph (c) shall not apply to such an individual.

SMALL GROUP TERMINATED FILE SAMPLE

Population	Sample Size	Number of Exceptions	Percentage of Sample
1,821	113	63	56%

The examiners reviewed a sample of 113 files that were randomly selected from a population of 1,821 small groups whose coverage was canceled during the exam period of January 1, 2007 through December 31, 2007. It appears that the Company is not in compliance with Colorado insurance law in that upon termination of the group policy for the reasons indicated below the Company failed to offer to each member of the terminating small group a choice of the Basic or Standard Health Benefit Plan as required by law.

NON-PAYMENT

In sixteen (16) cases there was an "Account Termination Notice" located in the files in which non-payment was indicated as the reason for termination, and this notice was sent only to the terminating employer, and stated:

Please advise your employees immediately that their coverage has been cancelled. If you are eligible for reinstatement, please contact 888-842-4571 within 30 days of the date of this letter. Note: Enrollees living in the state of Colorado may be eligible for Colorado Basic or Standard Health Benefit Plans. Please call the Conversion Customer Service Unit at (866) 747-1019.

POLICYHOLDER CANCELLED COVERAGE

In three (3) cases, described below in which the policyholder requested cancellation of coverage, there was no indication of any offer made concerning the Basic and Standard Health Benefit Plans:

(1) The employer's cancellation request indicated that the only employee had terminated 11 days prior to the requested cancellation date of 1/12/07.

(2) The employer's cancellation request indicated that the last employee terminated 11 days before the requested 2/1/07 cancellation date of the policy.

(3) The employer's cancellation request indicated that he was no longer offering health coverage for his three (3) employees.

NO REASON GIVEN

In forty-four (44) cases, the employer exercised their right to terminate the policy with no reason given. These files did not contain an "Account Termination Notice", only an "Account Summary". There was no documentation in the files indicating that any attempt was made to determine the reason for the employer requesting termination of the policy so that the Company could make a determination as to whether an offer of the Basic and Standard Health Benefit Plans was required.

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that each member of a terminating small group, for reasons other than replacement of coverage or fraud and abuse in procuring and utilizing coverage, is offered a choice of the Basic or Standard Health Benefit Plan in compliance with Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to accurately process claims.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance.

(f) Unfair discrimination:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, *or in the benefits payable thereunder*, or in any of the terms or conditions of such contract, or in any other manner whatever; [Emphasis added.]

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part II or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims under insurance policies;

(IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

Section 10-16-106.5, Prompt payment of claims – legislative declaration, states:

(1)(b) *Unnecessary delays in the payments of routine and uncontested claims for reimbursement represent an unwarranted drain on health care providers' resources,* which could be better spent attending to the needs of the patients, as well as wasting the time and money of the patients themselves. Therefore, it is in the interest of the citizens of Colorado that reasonable standards be imposed for the timely payment of claims. [Emphasis added.]

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(4)(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for

> such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

Colorado Insurance Regulation 4-2-24, Concerning Clean Claim Requirements for Health Carriers, promulgated under the authority of §§ 10-16-106.3(2), 10-16-109, and 10-1-109, C.R.S., states:

Section 6. Additional Information

A. A claim with all required fields completed is not considered "clean" if additional information is needed in order to adjudicate the claim. Carriers may request additional information *only if the carrier's claim liability cannot be determined with the existing information on the claim form* and the information requested is likely to allow a determination of liability to be made. [Emphasis added.] When additional information is required, the carrier shall make the specific request in writing within thirty calendar days after receipt of the claim form. *If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim.* [Emphasis added.] The specific information requested shall be requested within 30 calendar days after receipt of the claim form and identified for the provider upon request.

PAID CLAIMS INCORRECTLY PROCESSED

Population	Sample	Number of Exceptions	Percentage of Sample
1,233,895	109	5	5%

The Company provided a population of 1,233,895 paid claims received in 2007. A sample of 109 claims was randomly selected for review by the examiners. Of this sample it appears that five (5) claims were processed incorrectly.

- One (1) claim was paid with an incorrect contracted processing amount for an Emergency Room visit with reprocessing of the claim initiated by the provider's request. Late payment interest was paid on the additional payment of $235.00.

- One (1) claim was resubmitted with a corrected claim form and was not identified as a corrected billing and as a result was denied as a duplicate submission. The claim was subsequently identified as a corrected billing and processed with $1,860.09 paid to the provider. Although it appears that late payment interest and a penalty would have been required, there was no indication that either had been paid.

- One (1) claim was initially processed using an incorrect provider fee schedule allowance resulting in an underpayment of $36.21. Late payment interest was paid when the claim was re-processed.

- One (1) claim, received for a child's initial preventive medicine office visit, was initially incorrectly processed with a $25.00 co-pay being taken and reprocessed within the allowed time frame with no co-pay being taken.

- One (1) claim was denied twice for "Notification being required, but not received". The claim was resubmitted and processed almost seven (7) months later with payment in the amount of $665.00. It does not appear that any late payment interest or penalty was paid.

DENIED CLAIMS INCORRECTLY PROCESSED

Population	Sample	Number of Exceptions	Percentage of Sample
285,590	109	24	22%

The Company provided a population of 285,590 denied claims received in 2007. A sample of 109 claims was randomly selected for review by the examiners. Of this sample, it appears that twenty-four (24) claims were processed incorrectly.

- Thirteen (13) claims involved requests for other insurance information.
- Two (2) claims were incorrectly denied as duplicate submissions.
- Two (2) claims were incorrectly denied due to lack of notification to the Company.
- One (1) claim involved an incorrect denial of a vision claim.
- One (1) claim involved services provided by an out-of-network provider that had been authorized.
- One (1) claim involved an incorrect denial of a physician office visit for a biologically based mental illness diagnosis.
- One (1) claim involved an incorrect denial of physician charges for lab services.
- One (1) claim involved an incorrect denial of physician charges for infertility services.
- One (1) claim involved an incorrect denial of physician charges for services deemed experimental.
- One (1) claim involved an incorrect denial of physician charges for a routine office visit.

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, & 10-16-106.5., C.R.S. and Colorado Insurance Regulation 4-2-24. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all claims are processed correctly as required by Colorado insurance law.

Issue J2: Failure, in some instances to pay, deny or settle claims within the timeframes required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

ELECTRONICALLY RECEIVED PAID CLAIMS

Population	Sample	Number of Exceptions	Percentage of Sample
6,421*	109	104	95%

The Company provided a population of 10,858* electronically received paid claims that exceeded thirty (30) days to process. A sample of 109 files was randomly chosen for review. Of these claims, 104 files appeared to meet the definition of a "clean claim" submission, but were not paid correctly within the time period required by Colorado insurance law.

*The actual number of paid claims processed in excess of thirty (30) days was 10,858. However, due to an error in the sampling program the examiners only selected paid claims which were processed in more than forty-five (45) days. The examiners are of the opinion that not including paid claims between thirty (30) and forty-five (45) days would not have a material impact on the findings noted in the examination report.

PAPER RECEIVED PAID CLAIMS

Population	Sample	Number of Exceptions	Percentage of Sample
2,289	107	67	63%

The Company provided a population of 2,289 paid paper claims that exceeded forty-five (45) days to process. A randomly selected sample of 107 files was chosen for review. Sixty-seven (67) of these claims appeared to meet the definition of a "clean claim" submission, but were not paid correctly within the time period required by Colorado insurance law.

PAID CLAIMS EXCEEDING 90 DAYS TO PROCESS

Population	Sample	Number of Exceptions	Percentage of Sample
17,441	109	93	85%

The Company provided a population of 17,441 claims that had not been paid within ninety calendar days of receipt. A randomly selected sample of 109 files was chosen for review. It appears that the Company is not in compliance with Colorado insurance law in that ninety-three (93) of these claims did not include any indication of fraud, but were not paid or settled within the time period required by Colorado insurance law.

Recommendation No. 26:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-106.5., C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all claims are processed within the timeframes required by Colorado insurance law.

Issue J3: Failure, in some instances, to pay late payment interest and/or penalties.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

It does not appear that the Company has paid late payment interest and/or penalties in all required instances.

PAID ELECTRONIC CLAIMS OVER 30 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
6,421*	109	29	27%

The Company provided a population of 10,858* electronically received paid claims that exceeded thirty (30) days to process. A sample of 109 files was randomly chosen for review. Twenty-nine (29) of these claims appeared to meet the definition of a "clean claim", but were not paid correctly within the required time period and should have included interest. The Company agreed that late payment interest was due on these twenty-nine claims but had not been paid. The interest amounts were processed and paid during the examination with documentation of this provided to the examiners.

*The actual number of paid claims processed in excess of 30 days, but less than 90 days, was 10,858. However, due to an error in the sampling program the examiners only selected paid claims which were processed in more than 45 days, but less than 90 days. The examiners are of the opinion that not including paid claims between 30 and 45 days would not have a material impact on the findings noted in the examination report.

PAID NON-ELECTRONIC CLAIMS OVER 45 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
2,289	107	23	21%

The Company provided a population of 2,289, non-electronically received paid claims that exceeded forty-five (45) days to process. A sample of 107 files was randomly chosen for review. Twenty-three (23) claims appeared to meet the definition of a "clean claim", but were not paid correctly within the required time period and should have included interest. The Company agreed that late payment interest was due on these twenty-three claims but had not been paid. The interest amounts were processed and paid during the examination with documentation of this provided to the examiners.

PAID CLAIMS OVER 90 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
17,441	109	19	17%

The Company provided a population of 17,441 claims that had not been paid within ninety (90) calendar days from date of receipt. A sample of 109 files was randomly selected for review. Nineteen (19) claims appeared to be due late payment penalties that had not been paid. The Company agreed late payment penalties were due on these nineteen (19) claims but had not been paid. The penalty amounts were processed and paid during the examination with documentation of this provided to the examiners.

Recommendation No. 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that interest and/or penalties are paid on claims that are not paid or settled within the required time periods as required by Colorado insurance law. Additionally, a self audit should be performed to ensure that interest and penalties are properly disbursed on late claims.

Issue J4: Failure to correctly process claims for out-of-network services/treatment associated with services/treatment rendered at an in-network facility.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance.

(h) Unfair claim settlement practices: *Committing or performing, either in willful violation of this part II or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:*

(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims under insurance policies;

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; [Emphasis added.]

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section *shall be liable for the covered benefit and, in addition, shall pay to*

the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim *shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim.* [Emphasis added] Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

Section 10-16-704, C.R.S., Network adequacy – rules- legislative declaration – repeal, states:

(3)(b) When a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit. *Covered services or treatment rendered at a network facility, including covered ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider.* [Emphasis added]

The examiners noted that it appeared that the Company may not be processing out-of-network professional claims when services were provided at an in-network facility at the in-network benefit level in compliance with § 10-16-704(3), C.R.S.

When the examiners requested claims files to determine if the Company was complying with the above requirement, the Company advised that during 2007 the Division of Insurance had identified a concern wherein the Company was not processing certain claims submitted by out-of-network professional providers for services rendered at an in-network facility at the in-network benefit level. The Division addressed this concern with the Company in correspondence commencing on or about March 30, 2007.

In a letter June 15, 2007 to the Division the Company noted that:

- It had completed a self-audit which included a random sample of 200 claims
- That of the sample of 200 claims, 121 claims met the criteria
- That 102 of the 121 claims were processed correctly
- That nineteen (19) of the 121 claims had processing errors

The Company further noted in the letter of June 15, 2007 that "It appears that some claims are being processed incorrectly when the professional claims are received prior to the facility claims, because our claims system is unable to link the out of network professional claim with the in-network facility claim."

The Company also stated that it would review the full population of claims "to determine deficient claims and reprocess those claims with restitution to be made to the affected members in accordance with the member's benefit plan."

The Commissioner, in a letter dated July 6, 2007, advised the Company that:

- The Division is "deeply concerned with the harmful effects that UHC's noncompliance with § 10-16-704(3), C.R.S. has on Colorado consumers."

- That the Division is "troubled" that UHC has a systematic inadequacy which prevents it from linking out-of-network professional claims performed in an in-network facility when the out-of-network professional claim is received prior to the in-network facility claim.

- The Company was to provide a detailed summary of the procedures UHC has implemented to ensure that "all out-of-network professional claims are processed correctly when the professional claims are received prior to, but in connection with, an in-network facility claim."

- The Company was required to submit a "Certification of Compliance" signed by an officer of the Company.

The Certification of Compliance provided by UHC to the Division of Insurance stated:

> **"I HEREBY CERTIFY** that:
>
> 1. In Colorado, United Healthcare Insurance Company has discontinued the practice of paying out-of-network professional providers who render services at in-network facilities at less than the in-network benefit level, except where permitted to do so by Colorado law.
> 2. I have reviewed the requirements of Colorado Revised Statute section 10-16-704(3) and United Healthcare Insurance Company is in compliance with said law.
> 3. The self-audit of claims for out-of-network provider services rendered at in-network facilities has been conducted as required by the Colorado Division of Insurance all applicable claims identified and adjusted."

The Company responded, in a letter dated July 20, 2007, that it was "implementing the following procedures to ensure compliance with § 10-16-704(3), C.R.S.:

- A systematic claims process will be undertaken to associate an out-of-network professional claim with services rendered at an in-network facility to result in those claims being adjudicated at the in-network benefit level as required by Colorado law.

- United is undertaking an additional self audit for the time period of April 1, 2007 (for claims paid after the self audit was required by DOI) to present to ensure that members claims are being adjudicated in accordance with § 10-16-704(3), C.R.S.."

The Company provided the Division with a copy of the Certification of Compliance dated August 7, 2007 and signed by its Assistant Secretary, however, it modified paragraph 1 to read:

1. In Colorado, United HealthCare Insurance Company has modified its existing processes regarding payment of certain out-of-network professional providers who render services at in-network facilities to comply with Colorado law.

As a result of a request made by the examiners, the Company provided the examiners with a self-audit of 5,387 claims submitted for the time period 4/1/2007 through 12/31/2007, for non-network professional fees when services may have been performed at an in-network facility. The Company identified 395 claims where additional payments were made. The audit data did not indicate the reason for making the additional payment, only that such payment was made. The earliest date of adjustment was 8/28/2008.

The examiners note that for 143 of the additional payments, there was no interest paid and that for 395 of the additional payments, no penalty was applied. The Company also provided the examiners with its *Uniprise Policy and Procedures Transaction Operations, Colorado Non-Par Provider at Network Facility* wherein it indicates that the Company will conduct a "Monthly Review Process" "to ensure identification and adjustment of impacted claims." The procedures clearly indicate that the Company does not have the systematic procedures to identify on a "front-end" basis non-network professional claims where services were performed in an in-network facility when the non-network professional claim was received prior to the in-network facility claim.

The examiners conclude that:

- The Company, despite its statements in the letter of July 20, 2007 that "A systematic claims process will be undertaken to associate an out-of-network professional claim with services rendered at an in-network facility to result in those claims being adjudicated at the in-network benefit level as required by Colorado law", has not done so as the monthly review and adjustment of incorrectly processed claims does not meet the requirements for payment of claims in compliance with § 10-16-704(3), C.R.S..

- The Company is not in compliance with paragraph 1 of its Certification of Compliance in that it has not "modified its existing processes regarding payment of certain out-of-network professional providers who render services at in-network facilities to comply with Colorado law."

- The Company has not paid the applicable interest and penalty on claims as required by Colorado law.

It appears that the Company is in violation of Colorado insurance law as it relates to processing out-of-network professional claims when services are provided at an in-network facility because the Company has stated in written documents, including its Certification of Compliance that it is in compliance with Colorado law, when such is not the case.

OON PROFESSIONAL CLAIMS AT INN FACILITIES

Population	Sample	Number of Exceptions	Percentage of sample
4,279	108	29	27%

The examiners also randomly selected 108 claims from a population of 4,279 claims where it appeared that out-of-network (OON) professional services may have been provided in an in-network (INN) facility. The OON claims were identified from data provided by the Company indicating the status of the providers as being non-contracted. Upon review, the examiners determined that for various reasons fifty-eight (58) claims were not subject to in-network payment requirements, leaving a total of fifty (50) OON professional claims where services were provided in an INN facility and should have been paid at the in-network benefit level.

The examiners found that some OON professional claims were afforded discounts through a non-UHC network, or other shared savings programs. It appears that these programs permit the Company to access negotiated rates and that the member is not responsible for the discounted amount. However, the balance of the charges should be considered at the INN benefit level.

The examiners determined that twenty-one (21) of the fifty (50) OON professional claims appeared to have been processed correctly upon initial processing. However, it appeared that twenty-nine (29) of the claims were not processed correctly upon initial processing.

Recommendation No. 28:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, 10-16-106.5 and 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its claim payment procedures to ensure that all out-of-network professional claims are processed correctly when the claims are received prior to, but in connection with, an in-network facility claim in compliance with Colorado insurance law.

UTILIZATION REVIEW

Issue K1: Failure to provide correct information related to an insured's right to appeal adverse determinations.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 4 Definitions[1]

R. "Urgent care request" means:

1. A request for a health care service or course of treatment with respect to which the time periods for making a non-urgent request determination that,

a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or *for persons with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently* … [Emphasis added.]

Section 6 Standard Utilization Review

E. Requirements for adverse determination notifications

1. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

h. *A description of the health coverage plan's review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision*;… [Emphasis added.]

Section 10 First Level Review

D. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to Section 6 or 7 or after the receipt of notification of a benefit denied due to a contractual exclusion, *a covered person may file a grievance with the health carrier requesting a first level review of the adverse determination.* … [Emphasis added.]

J. *A first level review decision involving an adverse determination* issued pursuant to Subsection G. *shall include*, in addition to the requirements of Subsection I:

6(b) *The right of the covered person to*:

(ii) *Receive, upon request, a copy of the materials that the carrier intends to present at the review at least five (5) days prior to the date of the review meeting.* Any new material developed after the first five-day deadline shall be provided by the carrier when

practicable; [Emphases added.]

Section 11 Voluntary Second Level Review

A. *A carrier shall establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review*, at which the covered person has the right to appear in person or by telephone conference at the review meeting before a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, selected by the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the second level review decision. *The purpose of the voluntary review process is to give the covered person the opportunity to explain their grievance and to provide any relevant evidence in support of their claim for benefits*. [Emphases added.]

D. Within thirty (30) days after the date of receipt of a notice of an adverse determination, a covered person may file a request with the carrier requesting a voluntary second level review of the adverse determination.

Colorado Insurance Regulation 4-2-21, External Review Of Benefit Denials Of Health Coverage Plans, promulgated and adopted by the Commissioner of Insurance under the authority of §§10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states:

Section 6 Request for External Review

B. All requests for external review shall be made in writing to the carrier and *must include a completed external review request form as specified by the Division of Insurance*. [Emphasis added.]

D. *All requests for external review shall include a signed consent*, authorizing the carrier to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review. [Emphasis added.]

Section 8 Standard External Review

C. *Carrier requirements to provide documents and information*. [Emphasis added.]

1. Within six (6) working days from the date the carrier receives notice from the Commissioner pursuant to Paragraph 1. of Section 8.B., the carrier shall deliver to the assigned independent external review entity the following documents and information considered in making the carrier's adverse determination including:

e. *An index of all submitted documents*. [Emphasis added.]

Section 9 Expedited External Review

A. Request requirements.

1. Except as provided in Subsection I., of this Section 9, a covered person or the covered person's designated representative may make a request for an expedited external review with the carrier if the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 8 of this regulation would seriously jeopardize the life or health of the covered person, *would jeopardize the covered person's ability to regain maximum function* or, for persons with a disability, create an imminent and substantial limitation of their existing ability to live independently. [Emphasis added.]

   I. An expedited external review may not be provided for retrospective adverse determinations.

DENIED STANDARD UTILIZATION REVIEW DECISIONS

Population	Sample Size	Number of Exceptions	Percentage of sample
357	84	13	15%

United Healthcare has contracted with the ACN Group, Inc., Central Escalation Unit (CEU) for Colorado, and United Behavioral Health (UBH) to perform clinical review services. In order to obtain sample files from each of these multiple populations, the examiners totaled the populations from each category, and selected a proportional percentage of files from each type.

The examiners selected eighty-four (84) files for review from a population of 357 denied standard utilization review decisions. It appears that the Company was not in compliance with Colorado insurance law in that information provided for adverse determinations in thirteen (13) ACN files did not reflect correct/complete appeal rights.

The notification letter sent to the provider states that information regarding Appeal Rights is on the attached page or in a paragraph included within the notification letter which reflects:

> Reconsideration of denial of services may be filed by submitting a complete, written explanation of your request to ACN Group at the address listed above within thirty (30) calendar days of the date of this determination, as outlined in your provider operations manual. The request should include a copy of this letter and any supporting documentation. However, if you wish to appeal a denial of services on behalf of the member and/or insured, an appeal may be filed by calling the number listed above or by submitting a written request for approval within 180 days of the date of service. The submission should include a copy of this letter and any supporting documentation. An expedited appeal may be requested for emergencies.

There are two (2) pages titled "Your Right To Appeal".

The following is reflected on Page 1:

> The Standard Level Grievance Appeal Process
>
> Submit the appeal request in writing within 180 calendar days of the adverse determination to the following address:

UnitedHealthcare Central Escalation Unit
P.O. Box 30573
Salt Lake City, UT 84130-0573

This part of the company's notice is incorrect:

(1) Appeal process titled as "The Standard Level Grievance Appeal Process" appears to be a "First Level Review"

CEU DENIED RETROSPECTIVE REVIEW DECISIONS

Population	Sample Size	Number of Exceptions	Percentage of sample
445	84	84	100%

The examiners selected eighty-four (84) files for review from a population of 445 CEU denied retrospective review decisions. It does not appear that the information provided for adverse determinations reflects correct or complete appeal rights in all eighty-four files.

The Appeal Rights, included as an enclosure with the notification letter, reflects:

UNITED HEALTHCARE APPEAL PROCESS FOR COLORADO

The following is reflected on Page 3 of the notification letter:

How to initiate a Standard First Level Review

You or your representative may submit your grievance in writing within 180 calendar days of the adverse determination to the address identified in the enclosed letter. …

United Healthcare Central Escalation Unit
P. O. Box 30573
Salt Lake City, UT 84130-0573

This part of the company's notice is incorrect:

(1) Appeal process titled as "Standard First Level Review" appears to be a "First Level Review".

This part of the company's notice is incomplete:

(1) Nothing is reflected regarding the insured's right to receive, upon request, a copy of the materials to be presented at the review at least five (5) days prior to the review meeting.

(2) Nothing is reflected concerning the carrier's requirement to provide an index of all submitted documents to the assigned independent external review entity.

(3) The description of when an expedited external review may be requested does not reflect when the timeframe, for persons with a physical or mental disability, would create an imminent and substantial limitation on their existing ability to live independently.

(4) Nothing is reflected to indicate that an expedited external review may not be provided for retrospective adverse determinations.

Recommendation No. 29:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulations 4-2-17 and 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that its appeal procedures reflect complete and correct information regarding a member's appeal rights as required by Colorado insurance law.

Issue K2: Failure to provide written notification to a covered person of a review meeting within the required time frame.

Colorado Insurance Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review And Denial Of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

Section 11 Voluntary Second Level Review

G. A health carrier's procedures for conducting a voluntary second level review shall include the following:

1. The reviewer or review panel shall schedule and hold a review meeting within sixty (60) days of receiving a request from a covered person for a voluntary second level review. *The covered person shall be notified in writing at least twenty (20) days in advance of the review date.* The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person. [Emphasis added.]

CENTRAL ESCALATION UNIT (CEU) SECOND LEVEL APPEALS

Population	Sample	Number of Exceptions	Percentage of sample
13	13	12	92%

The examiners reviewed the entire population of thirteen (13) Central Escalation Unit (CEU) processed second level reviews. It appears that the Company was not in compliance with Colorado insurance law in that in twelve (12) files, the required twenty (20) day advance notification of a review meeting was not given to covered persons.

UNITED BEHAVIORAL HEALTH (UBH) SECOND LEVEL APPEALS

Population	Sample	Number of Exceptions	Percentage of sample
11	11	3	27%

The Company provided a population of twelve (12) United Behavioral Health, (UBH) Second Level processed appeals. One (1) file was determined to be a case in which the member resided in and received treatment in Texas, and this file was removed from the sample. The Company does not appear to be in compliance with Colorado insurance law in that in three (3) instances, the required twenty day advance notification of a review meeting was not given to covered persons.

Recommendation No. 30:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notification of meetings held for voluntary second level reviews is provided within the time frames required by Colorado insurance law.

Issue K3: Failure to provide the location of the review panel meeting and thereby discouraging the covered person from requesting a face-to-face meeting.

Colorado Insurance Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review And Denial Of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 11. Voluntary Second Level Review

A. A carrier shall establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the right to appear in person or by telephone conference at the review meeting before a health care professional (reviewer) or, if offered by the health carrier, a review panel of health care professionals, selected by the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the second level review decision. The purpose of the voluntary review process is to give the covered person the opportunity to explain their grievance and to provide any relevant evidence in support of their claim for benefits.

G. A health carrier's procedures for conducting a voluntary second level review shall include the following:

3. *Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting*. Whenever a covered person has requested the opportunity to appear in person, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate, at the health carrier's expense, by telephone conference call. A carrier may also offer video conferencing or other appropriate technology. [Emphasis added.]

It appears that the Company is not in compliance with the requirements of Colorado insurance law with regard to instances in which there were review panel meetings scheduled. The Company discouraged the covered person and/or their designated representative from requesting a face-to-face meeting by not fully disclosing the location of the review panel meeting.

The Company's notification letter to the covered person advising of the review date only stated the following concerning the review panel meeting:

> The second level panel appeal process involves a panel review. A minimum of three individuals will be appointed by UBH to the panel to review your case. The panel may be composed of employees of UBH who have appropriate professional expertise. A majority of the panel will be comprised of persons who were not previously involved in the adverse determination. This panel will review your case on (date and time inserted here). If you wish to attend the panel, either in person or through teleconference, please contact UBH at the address, fax number, or telephone number below.

United Behavioral Health (UBH) Files

A population of twelve (12) second level review, UBH-processed files, was provided by the Company for review by the examiners. One (1) file was determined to be a case in which the member resided in and received treatment in Texas and this file was removed from the sample. Of the eleven (11) remaining files that were reviewed, eight (8) were determined to be cases in which a review panel meeting was scheduled and the location of the review panel meeting was not fully disclosed.

UTILIZATION REVIEW-UBH-SECOND LEVEL REVIEW

Population	Sample	Number of Issues	Percentage of sample
11	11	8	73%

Central Escalation Unit (CEU) Files

A population of thirteen (13) second level review, CEU-processed files, was provided by the Company for review by the examiners. Of the thirteen (13) files reviewed eleven (11)were determined to be cases in which a review panel meeting was scheduled and the location of the review panel meeting was not fully disclosed.

UTILIZATION REVIEW-CEU-SECOND LEVEL REVIEW

Population	Sample	Number of Issues	Percentage of sample
13	13	11	85%

Recommendation No. 31:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that disclosure of the location of the second level review panel meeting is provided in all notification letters so covered persons and/or their representatives are not discouraged from requesting face-to-face meetings as required by Colorado insurance law.

Issue K4: Failure to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.

Section 10-16-113, C.R.S., Procedure for denial of benefits – rules, states in part:

> 4. All written denials of requests for covered benefits on the ground that such benefits are *not medically necessary, appropriate, effective, or efficient shall be signed by a licensed physician familiar with standards of care in Colorado.* … [Emphasis added.]

CENTRAL ESCALATION UNIT (CEU) - FIRST LEVEL REVIEW

Population	Sample	Number of Exceptions	Percentage of sample
146	46	36	78%

The examiners reviewed a sample of forty-six (46) first level review files from a population of 146 provided by the Company as being processed by the Central Escalation Unit (CEU). In thirty-six (36) of these files a determination was made to uphold the prior denial of requests for covered benefits. It does not appear that the Company is in compliance with Colorado insurance law as the thirty-six (36) files contained notification of denial for benefits as "Experimental", "Investigational" and "Unproven", or services "subject to exclusions and limitations," or in the case of a piece of durable medical equipment, "not the most cost effective piece of equipment". These letters were not signed by a licensed physician but by a "Resolving Analyst".

CENTRAL ESCALATION UNIT (CEU) - SECOND LEVEL REVIEW

Population	Sample Size	Number of Exceptions	Percentage of sample
13	13	9	69%

The examiners reviewed the population of thirteen (13) second level review files provided by the Company as being processed by the Central Escalation Unit (CEU). In nine (9) of these files a determination was made to uphold the prior denial of requests for covered benefits. It does not appear that the Company is in compliance with Colorado insurance law as these nine (9) files contained notification of denial for benefits as "Experimental", "Investigational" and " Unproven" or in the case of a piece of durable medical equipment, "not the most cost effective piece of equipment". These letters were not signed by a licensed physician but by a "Resolving Analyst".

Recommendation No. 32:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient are be signed by a licensed physician familiar with standards of care in Colorado as required by Colorado insurance law. Additionally, the company should ensure that all cases signed by a "Resolving Analyst" are reviewed by a licensed physician, and that any corrections necessitated by the physician review are made.

Issue K5: Failure, in some cases, to send written notification of adverse retrospective determinations.

Section 10-16-113, C.R.S., Procedure for denial of benefits – rules, states in part:

(1)(a) A health coverage plan shall not make a determination, in whole or in part, that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.

(2) Following a denial of a request for benefits by the health coverage plan, *such plan shall notify the covered person in writing*. The content of such notification and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner. [Emphasis added.]

Colorado Insurance Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review And Denial Of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

Section 6 Standard Utilization Review

C. Retrospective review determinations.

1. For retrospective review determinations, a health carrier shall make the determination *and notify the covered person and the covered person's provider of the determination within a reasonable period of time,* but in no event later than thirty (30) days after the date of receiving the benefit request. If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection E. [Emphasis added.]

UHC DENIED RETROSPECTIVE DETERMINATIONS

Population	Sample	Number of Exceptions	Percentage Of sample
445	84	27	33%

It appears that the Company is not in compliance with Colorado insurance law in that written notification of adverse determinations were not sent in some cases. The examiners reviewed a sample of eighty-four (84) UHC Denied Retrospective Determination files. In response to an examiner's inquiry concerning the lack of written notification of an adverse determination in some files, the Company responded that some cases that should have been referred to Medical Claim Review (MCR) for a review were not, and without the MCR review there was no notification of adverse determination letter sent out, only the claim EOB. There were nineteen (19) cases that did not contain a notification letter of adverse determination that were processed without MCR review.

There were eight (8) additional cases that had been reviewed by MCR, but in which the file indicated that no letter was sent or the Company was unable to produce the letter.

Recommendation No. 33:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. and Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that notification of adverse determinations are sent in all applicable instances in compliance with Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS	Rec. No.	Page No.
COMPANY OPERATIONS AND MANAGEMENT		
Issue A1: Certifying and using forms that do not comply with Colorado insurance law.	1	19
Issue A2: Failure to provide correct form numbers for some forms reported on the Annual Report of Policy Forms as being in use during 2007.	2	21
Issue A3: Failure, in some instances, to maintain records required for market conduct purposes.	3	22
Issue A4: Failure to report to the Division the correct number of second level and independent external appeals requested and completed in 2007.	4	23
COMPLAINTS		
Issue C1: Failure to enter all written first level and second level reviews into the Company's complaint record.	5	25
CONTRACT FORMS		
Issue E1: Failure to reflect that there is no age limit for the mandated coverage to be provided for treatment of cleft lip and/or cleft palate.	6	28
Issue E2: Failure to disclose the existence and availability of an access plan in health benefit plans.	7	29
Issue E3: Failure to reflect mandatory repair and replacement coverage to be provided for prosthetic devices.	8	31
Issue E4: Failure to specify the period to be used for mammogram coverage.	9	32
Issue E5: Failure to allow benefits for covered services based on a licensed provider's status as a member of the insured's family or having the same legal residence.	10	34
Issue E6: Failure to reflect accurate requirements to qualify as a dependent.	11	36
Issue E7: Failure to accurately reflect the coverage to be offered for Home Health Services and Hospice Care. (*This was prior issue E2 in the findings of the 2002 final examination report.*)	12	43
Issue E8: Failure to reflect correct coverage for court-ordered substance abuse treatment.	13	44
Issue E9: Failure to reflect the mandated minimum hours of hospital stay to be provided for normal and cesarean section deliveries.	14	46
Issue E10: Failure to utilize a fraud statement that is substantially the same as required by Colorado insurance law.	15	48

Issue K4: Failure to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.	32	94
Issue K5: Failure, in some cases, to send written notification of adverse retrospective determinations.	33	96

Examination Report Submission

Independent Contract Market Conduct Examiners

Regulatory Consultants, Inc.

Nestor J. Romero, CPA, CFE, CIE
Examiner-In-Charge

Jimmy Potts, FLMI, CLU, AIRC, CIE

Sarah S Malloy, CIE, AIRC, PAHM, HIA, LTCP, ACS, MCM

Lynn L. Zukus, AIE, FLMI

For

The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202

Participated in this examination and in the preparation of this report.